Montana Patient-Centered Medical Home Program

2017 Public Report
August 31, 2017

A report on the third year of the Montana program implementation.

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Montana Patient-Centered Medical Home Program

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SECTION I: INTRODUCTION

The Montana Patient-Centered Medical Home Program (PCMH) has completed its third year, and this report contains data from 2016. PCMHs in Montana deliver high-quality, efficient primary care with an increased focus on prevention and disease management. In order to qualify for the Montana PCMH program, healthcare providers must submit a Comprehensive Application, obtain recognition from an approved recognition agency and report on 4 out of 5 quality-of-care "metrics" identified by the Commissioner in administrative rule. A qualified clinic in the Montana PCMH program can promote and market itself as a PCMH and can engage in PCMH enhanced compensation contracts with Montana PCMH payors, including Medicaid. The PCMH healthcare providers and payors report on quality and utilization measures, which allows the program to gauge its success against documented national health outcomes and utilization benchmarks and the federal Healthy People 2020 targets.

What is a PCMH?

A patient-centered medical home is not a building, house, or hospital. It is a team of healthcare professionals that transform their focus from just treating illness after the fact to keeping patients healthy and avoiding expensive complications. A PCMH utilizes a "team" of people in various positions, such as physicians, physician assistants, nurse practitioners, nurses, care coordinators, dieticians, behavioral health consultants, and pharmacists to coordinate all aspects of a patient's health. The care team engages the patient as an active participant in their healthcare through better communication regarding the individual's responsibility for their own health. PCMHs provide a comprehensive approach to healthcare, addressing every aspect of a patient's health, at all stages of life. PCMHs coordinate care with other parts of the healthcare system such as specialty healthcare providers, hospitals, and nursing homes. Some PCMHs also connect patients to community resources such as affordable housing or affordable health insurance. PCMHs prevent and manage disease better by following up with patients to ensure that preventive care and necessary treatment for chronic disease is delivered in a timely and appropriate manner.

History of the Montana PCMH Law

The Montana Patient-Centered Medical Home Act became law on April 30, 2013, and its provisions are contained in Mont. Code Ann. Title 33, Chapter 40. Council members included healthcare providers, health insurers, representatives from the state Medicaid division, and consumer advocates. The bill codified the definition of a patient-centered medical home in Montana state law and established a governance structure for the state-wide program. The Act requires PCMH providers and payors to report to the Commissioner on their compliance with those measures. The Act allows the Commissioner to qualify patient-centered medical homes that have obtained recognition from an approved accrediting agency and that meet the standards set in rule.

The Montana PCMH Act establishes anti-trust protection through ongoing state involvement in the oversight of the program. The law's anti-trust protection allows multiple payors and providers to share the cost of transforming a medical practice into a PCMH.

The law further provides for government agency oversight, but requires input from interested parties through the creation of a stakeholder council. The stakeholder council has met monthly since November 2013 and also has several subcommittee meetings each month.

Stakeholders met twice in 2017, fulfilling the obligation for two meetings a year.

The PCMH Act, passed in 2013 has a termination date of December 31, 2017. The PCMH Act was not extended beyond that date by the 2017 Montana Legislature.

Program Governance and Administrative Rules

In September 2013, the CSI worked with stakeholders and adopted the program's first set of administrative rules. According to the rules, a PCMH healthcare provider must apply for qualification and receive approval from the Commissioner before promoting itself as a medical home. Payors may only use healthcare providers qualified by the Commissioner as PCMHs when offering "medical home" services to covered individuals. The rule allows the Commissioner to "provisionally qualify" a patient-centered medical home for one year if the practice needs additional time to obtain recognition. Furthermore, the Commissioner may extend the provisional status one time only, for an additional six months. There are three accrediting agencies the Commissioner has approved for Montana PCMHs to seek recognition from: The National Committee for Quality Assurance [NCQA], The Joint Commission [JCo], and The Accreditation Association for Ambulatory Health Care [AAAHC]. A list of PCMHs can be found on the CSI website at these links: Qualified PCMHs and Provisionally Qualified PCMHs. At the end of 2016, there were 68 PCMHs in Montana.

Stakeholder Council Duties

The September 2013 rules also established the PCMH Stakeholder Council duties and required reporting timelines. The stakeholder council consists of 15 members who represent some of the interested parties identified in Mont. Code Ann. 33-40-104: the Department of Public Health and Human Services, public health agencies, health plans, government health plans, primary care providers,

and healthcare consumers. The Commissioner selects stakeholders from those who submit a letter of interest. Council members serve a 12-month term. The first council convened in November 2013. The stakeholder council is consulted on all consequential decisions regarding the PCMH program.

Quality Metrics

The Montana PCMH Act authorizes the Commissioner to set standards for PCMH's, (Mont. Code Ann. 33-40-105(2) (c)). In Year 1, the program adopted four quality measures and PCMHs reported 2014 data on blood pressure control, diabetes control, tobacco screening and cessation/ intervention and childhood immunizations. In Year 2, the PCMH Stakeholder Council recommended adding a depression screening measure. The administrative rules were revised to add screening for clinical depression and follow-up plan for individuals age 12 and older. However, the rules maintained flexibility by allowing PCMHs to report three out of the five measures to the Commissioner in 2016. Beginning with the 2017 report (for the 2016 calendar year measurement period) a PCMH must choose and report on four out of five measures. These rules also require qualified and provisionally qualified PCMHs to report annually to the Commissioner on their performance related to the healthcare quality metrics, pursuant to Mont. Code Ann. 33-40-105 (5). The reports enable the Montana PCMH Program to measure quality improvement over time for the program as a whole. Summary data from the PCMH 2016 quality metric reports submitted in 2016 is in Section II of this report.

Payment Methods and Utilization Measures

The Montana PCMH Program also established rules, pursuant to Mont. Code Ann. 33-40-105(2) (a) and (d), on standards for payment methods and measures relating to cost and medical usage (utilization measures). In Years 1 & 2, PCMH payors reported on two measures: emergency room visits and hospitalizations. (Summary data on PCMH payors' Year 2 utilization measure reports is in Section IV.) Montana payors that wish to establish a patient-centered medical home program for their members must submit a letter of intent to the Commissioner, describing how their proposed method of compensating providers meets the requirements of the statute and the rule. Payment models must support enhanced primary care and promote the development of patient-centered medical homes.

Payment methods may include payment for achieving patient-centered medical home recognition status; reimbursement for patient-centered medical home services such as care coordination, disease management, population health management, the integration of behavioral health services into primary care, and clinical pharmacist services. Montana administrative rule allows for payment for improvement in quality metrics, shared savings incentives, block grants to enhance patient-centered medical home capabilities of practices, and other types of payment that the Commissioner approves as supporting the goals of the Montana PCMH Program. The Commissioner reviews and approves or disapproves the letters of intent. Currently, there are four approved payors, including Medicaid.

SECTION II: QUALITY METRIC DATA ANALYSIS

PCMHs were required by administrative rule to report data on four of the five following quality metrics:

1. Blood pressure control among adults with diagnosed hypertension
2. Poor control of A1C levels in adults diagnosed with diabetes
3. Screening for tobacco use and tobacco cessation counseling/intervention for adults
4. Age-appropriate immunization for children who turned aged three during the measurement period
5. Screening for clinical depression and follow-up plan for individuals age 12 and older

The program maintained the first four measures from the first year of the program to track trends and look for improvement. They are common health indicators that represent major health issues in Montana. Each of these metrics has considerable potential to improve health outcomes for PCMH patients. These metrics also align with public health goals.

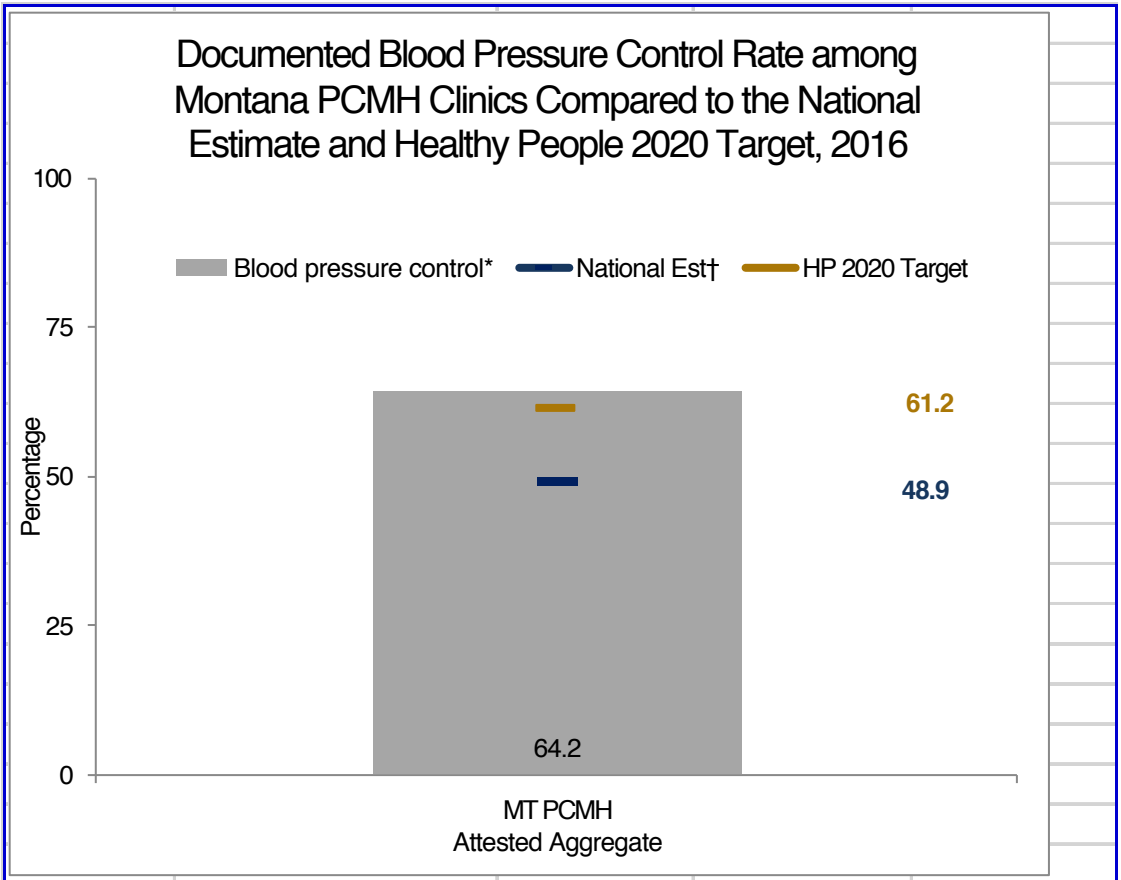
Addition of the Depression Screening and Follow-up Plan Measure

The additional fifth metric, depression screening and follow-up plan, was optional for clinics due to the continued flexibility in the rule to report on only three of the five possible measures in 2016. PCMHs shall chose four out of five measures to report data on in 2017, for the 2016 calendar year measurement period. The program maintained the flexibility to allow 2016 to be a trial year for the depression metric. Stakeholders decided gradual implementation of the depression metric was the best approach to take for several reasons: it is a newer measure that many clinics do not have extended experience with reporting; many EMRs are not fully equipped to capture and report this data; and this two-part metric is difficult for establishing standardized workflows and processes in both care delivery and data entry and extraction.

Practices reported on attested aggregate data in 2016 only.

The following charts provide data for the above five listed measures:

Figure 1:

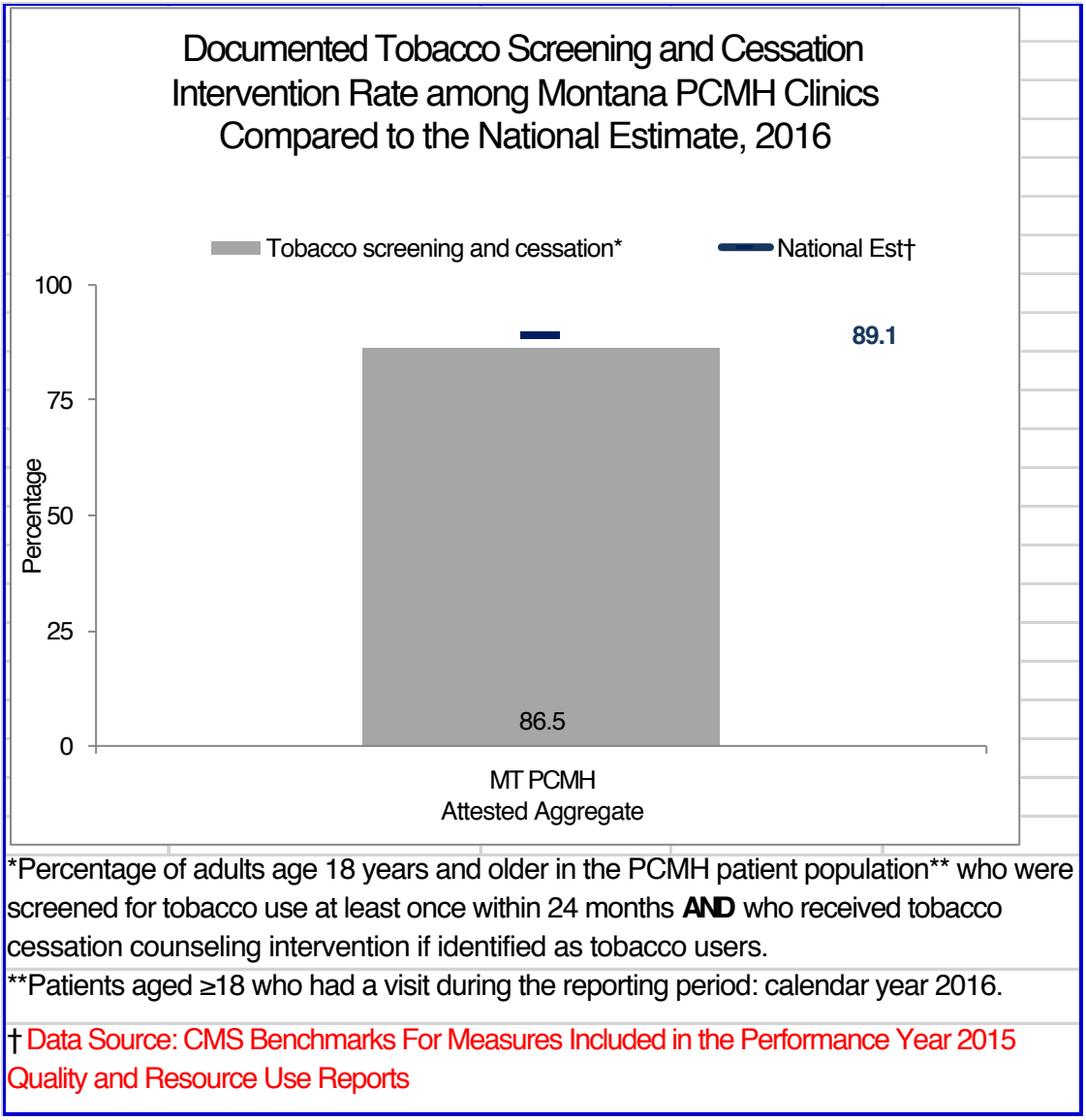


*Percentage of adults aged 18 through 85 years in the PCMH patient population**, who had a diagnosis of hypertension and documented systolic <140mmHg and diastolic blood pressure <90mmHg and who had a visit during the reporting period.

**Who (a) have the diagnosis of hypertension, including ICD-9 code groups 401.0, 401.1, 4.1.9 or ICD-10 I10 and (b) had one or more outpatient visits during the reporting period: calendar year 2016.

† Data Source: National Health and Nutrition Examination Survey 2009-2012

Figure 2:

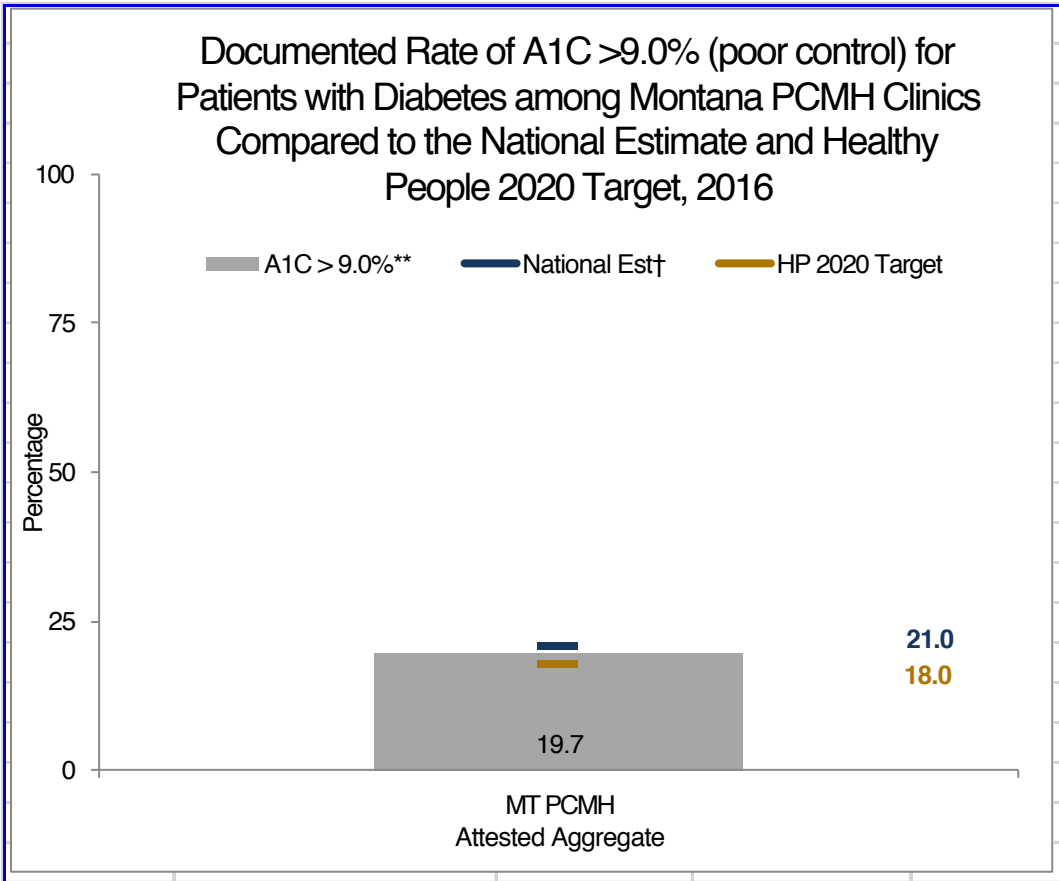


*Percentage of adults age 18 years and older in the PCMH patient population** who were screened for tobacco use at least once within 24 months **AND** who received tobacco cessation counseling intervention if identified as tobacco users.

**Patients aged ≥18 who had a visit during the reporting period: calendar year 2016.

† Data Source: CMS Benchmarks For Measures Included in the Performance Year 2015 Quality and Resource Use Reports

Figure 3:

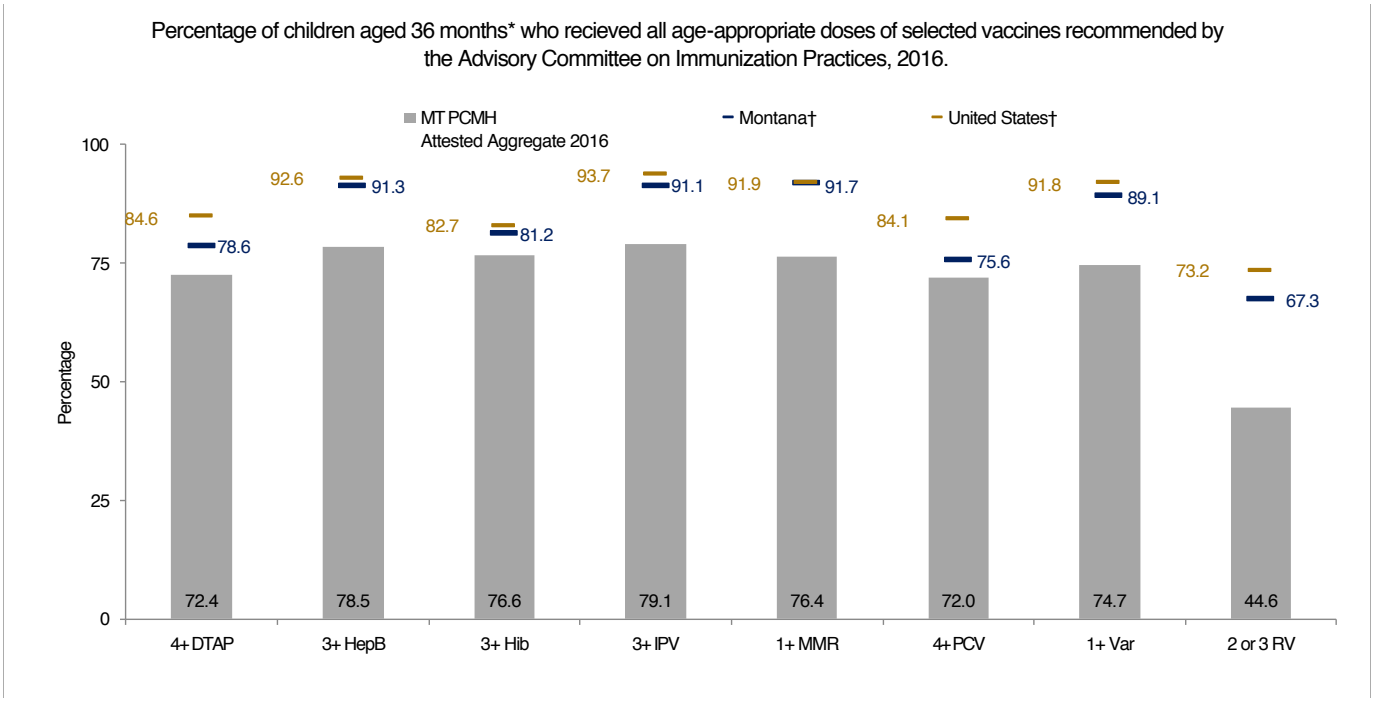


*Percentage of adults aged 18 through 75 years in the PCMH patient population** with (a) a diagnosis of diabetes who had hemoglobin A1c >9.0%. For diagnosis codes refer to http://csimt.gov/wp-content/uploads/2016PCMHQualityMetricsGuidancePacket.pdf and (b) had one or more outpatient visits during the reporting period: calendar year 2016.

**Percentage of the adults described above, for whom the most recent documented A1C during the reporting period was >9.0% or there was no measured A1C.

† Data Source: National Health Interview Survey 2011 for estimate of prevalence of diabetes among adults and National Health and Nutrition Examination Survey 2009-2012 for estimate of proportion of diabetic patients with A1C > 9.0%

Figure 4:



*All children in the PCMH population who had a 3rd birthday during the measurement period of calendar year 2016 and who had one or more outpatient visits during 2016.

DTaP = diphtheria and tetanus toxoids and acellular pertussis vaccine; HepB = hepatitis B vaccine; Hib = *Haemophilus influenzae* type B conjugate vaccine; IPV = inactivated poliovirus vaccine; MMR = measles, mumps, and rubella vaccine; PCV = pneumococcal vaccine; VAR = varicella vaccine; RV = Rotovirus.

§Combined series (4:3:1:3:3:1:4) includes ≥4 doses of DTaP, ≥3 doses of IPV, ≥1 dose of MMR, full series of Hib (≥3 doses for PCMH data, 3 or 4 doses for NIS depending on product type), ≥3 doses of HepB, ≥1 dose of VAR, ≥4 doses of PCV, 1 dose of HepA, 2 or 3 doses of RV and 2 doses of Flu. MT and US data benchmarks are not compatible due to changes in definitions for combined series, 1HepA and 2Flu and therefore were not reported.

†Data Source: National Immunization Survey (NIS); estimated immunization coverage for children aged 19–35 months during 2014.

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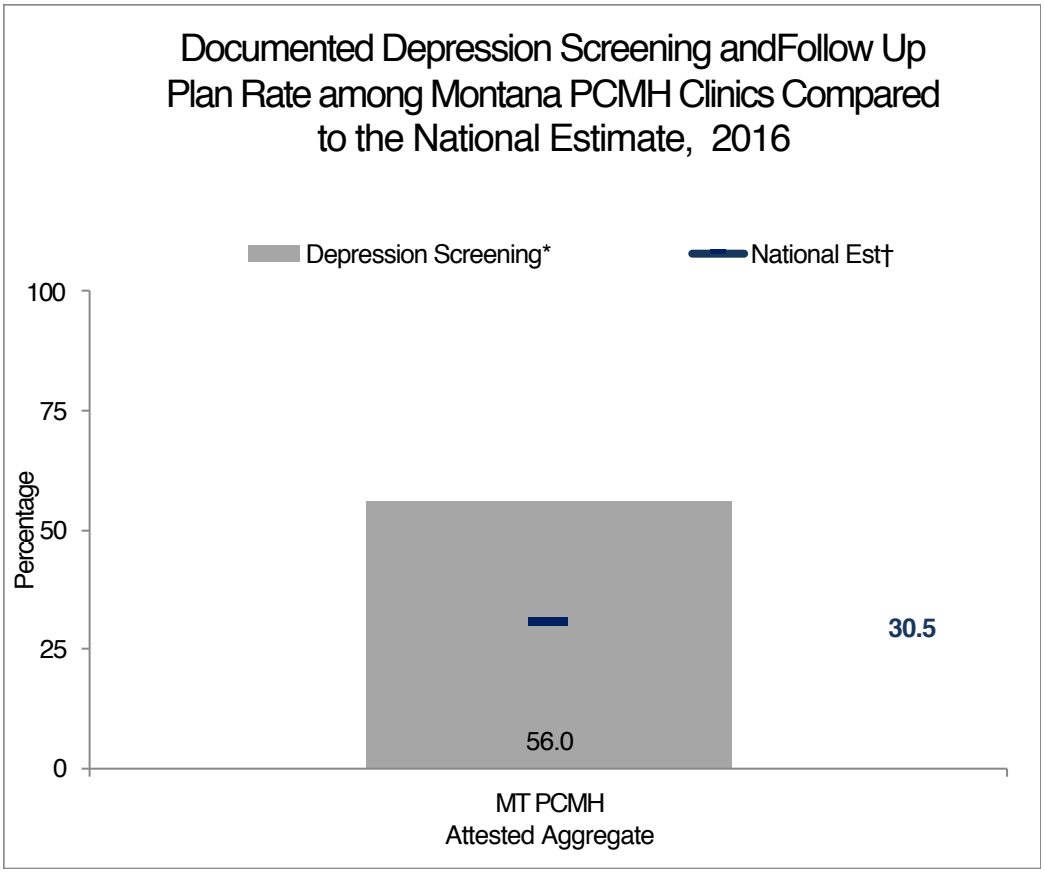
Figure 5:



*Percentage of patients aged 12 years or older in the PCMH patient population** who were screened for depression on the date of encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen.

**Patients aged ≥ 12 who had a visit during the reporting period: calendar year 2016.

† Data Source: CMS Benchmarks For Measures Included in the Performance Year 2015 Quality and Resource Use Reports

SECTION III: UTILIZATION MEASURE DATA ANALYSIS

The PCMH Act requires the Commissioner to adopt rules establishing a "uniform set of measures related to cost and medical usage." The rule adopted on utilization measures requires all PCMH payors to report to the Commissioner on emergency room (ER) visits and hospitalization rates.

It is important to collect data separately on ER visits that do and do not lead to hospitalizations because CMS and PCMHs feel that they are more able to limit ER visits that do not lead to hospitalization. It is those types of visits that should and could be handled with enhanced or afterhours access to care by PCMHs.

There are several limitations to this data that must be considered when reviewing it. Limitations are summarized below:

- The data is not based on a randomized controlled trial, therefore the data are not statistically significant and the results do not provide any definitive answers. However, it may show trends that could serve as a basis for future data analysis or study design.
- The PCMH data is compared to all-patient data, which includes PCMH attributed patients rather than comparing PCMH to non-PCMH data. In addition, clinics which function as PCMHs *typically* provide these services to all patients in a clinic, not only to those patients who are attributed to a payor providing PCMH enhanced reimbursement.
- In addition, there may be some migration toward patient-centered, team-based care even if a practice has not been recognized as a PCMH by Montana's PCMH program. Non-PCMH clinics may be offering similar benefits to patients which we know nothing about.
- There are many newly insured people as a result of increased access to insurance coverage. These patients may have been accustomed to getting treatment in the emergency department and may have had previously untreated conditions for which they sought treatment in the emergency department once they had insurance.
- Patient populations also differed. Some payers had a higher percentage of children and some had a higher percentage of FQHCs, groups that may have higher emergency department use or hospitalization rates.
- PCMH implementation is new in Montana with few patients and payors participating in PCMH models in 2014-2015. It is known from similar work in other states that changes in PCMH-related outcome measures may take several years to observe.

Table 1 presents the results for the rate of emergency department (ED) admissions and the rate of ED visits that do not result in an admission for all payors for 2016. One Payor did not report.

Table 1: Emergency department visits per 1000 member months, 2016				
	ED Visits/1000		ED visits that lead to hospitalization	
	PCMH	All	PCMH	All
Payor A	163.32	159.06	21.27	18.03
Payor B	72.44	52.14	7.05	4.67
Payor C	N/A	193.64 *	N/A	3.18*

*No completion factor
**IP hospitalization, completion factor 0.98

SECTION V: CONCLUSION AND PLANS FOR 2017

The PCMH Act was not reauthorized by the Montana State Legislature and will end on December 31st of 2017. The CSI appreciates the work and support of the Stakeholder Council and the participating Payors in 2016.

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